# CLINICAL QUALITY MEASURE

# CURRENT CMS MEASURE RELATED TO DIABETES

- Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c> 9% during the measurement period
- Do we want to define measurement period?
- Other data related to diabetes we would like to measure?
- Other Options?

# STANDARDS RELATING TO DIABETES

# STANDARD 3 ELEMENT D (MUST PASS)

Factor 3: At least three different chronic or acute care services.

- The practice generates lists (registries) of patients who need chronic care or acute management services and uses the lists to remind identified patients of at least three chronic or acute care services:
  - HbA1c measurement is appropriate for patients with diabetes and meets criteria for factor 3 (chronic care services).

# STANDARD 4 ELEMENT B (MUST PASS)

- The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75 percent of the patients identified in Element A (Patients that may benefit from care management with poorly controlled or complex conditions):

  Factor 1. Incorporates patient preferences and functional/lifestyle goals.

  Factor 2. Identifies treatment goals.

  Factor 3. Assesses and addresses potential barriers to meeting goals.

  Factor 4. Includes a self-management plan.

  Factor 5. Is provided in writing to the patient/family/caregiver.

# CARE PLANS

- A care plan considers and/or specifies various areas related to a patient's care, which could include:
  - Patient preferences and functional/lifestyle goals.
  - Treatment goals.
  - Assessment of potential barriers to meeting goals.
  - Strategies for addressing potential barriers to meeting goals.
  - Care team members, including the primary care provider of record and team members beyond the referring or transitioning provider and the receiving provider.
  - Current problems (may include historical problems, at the practice's discretion).
  - Current medications.
  - Medication allergies.
  - A self-care plan.

- A plan of care is tailored for the patient's use at home and to the patient's understanding (e.g., a diabetes action plan).

# STANDARD 6 ELEMENT A

At least annually, the practice measures or receives data on:

Factor 3: At least three chronic or acute care clinical measures.

- Chronic or acute care clinical measures may be associated with the conditions that are tracked by the practice (e.g., diabetes, heart disease, asthma, depression, chronic back pain, otitis media), based on evidence-based guidelines. The practice may choose one measure from each of three or more different conditions. Three or more measures related to a specific condition meet the requirement.

# STANDARD 6 ELEMENT C

At least annually, the practice obtains feedback from patients/families on their experiences with the practice and their care.

Factor 3: The practice obtains feedback on experiences of vulnerable patient groups

- Vulnerable populations are "those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability," (AHRQ) and include people with multiple co-morbid conditions or who are at high risk for frequent hospitalization or ER visits.
- The practice uses a survey or another method to assess quality of care for its vulnerable subgroups. Patient self-identification in the survey may provide the basis for the subgroups.

# STANDARD 6 ELEMENT D (MUST PASS)

The practice uses an ongoing quality improvement process to:

Factor 1. Set goals and analyze at least three clinical quality measures from Element A.

Factor 2. Act to improve at least three clinical quality measures from Element A.

Factor 3. Set goals and analyze at least one measure from Element B.

Factor 4. Act to improve at least one measure from Element B.

Factor 5. Set goals and analyze at least one patient experience measure from Element C.

Factor 6. Act to improve at least one patient experience measure from Element C.

Factor 7. Set goals and address at least one identified disparity in care/service for identified vulnerable populations.

# STANDARD 6 ELEMENT D

Factors 1–6: The practice sets goals and acts to improve performance, based on clinical quality measures (measures identified in Element A), resource and care coordination measures (measures identified in Element B) and patient experience measures (measures identified in Element C). The goal is for the practice to reach a desired level of achievement based on its self-identified standard of care. No show rates are not acceptable.

Factor 7: The practice identifies areas of disparity among vulnerable populations and makes a comparison to the general population. The practice then sets goals, and acts to improve performance in these areas. Vulnerable groups reflect the practice's population demographics (e.g., age, gender, race, ethnicity, language needs, education, income, type of insurance [i.e., Medicare, Medicaid, commercial], disability or health status).

# STANDARD 6 ELEMENT G

Factor 5: The practice demonstrates the capability to identify and report specific cases to a specialized registry (other than a cancer registry) electronically.

- The practice attests that it has "successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period."